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Statement of Buford Rolin
Chairman
National Indian Health Board
On the
Fiscal Year 2000 Indian Health Service Budget
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Chairman Ben Nighthorse Campbell, Vice-Chairman Daniel Inouye, and distinguished members of the United States Senate Committee on Indian Affairs, I am pleased to offer testimony on behalf of the National Indian Health Board (NIHB) on the Fiscal Year (FY) 2000 Indian Health Service (IHS) Budget. The NIHB serves all 558 Tribal Governments in advocating for the improvement of health care delivery. Our Board Members represent each of the twelve Areas of the Indian Health Service and are generally elected at-large by their respective Tribal Governmental Officials within their regional area. We have the duty to ensure that the solemn treaty commitments of our ancestors are upheld in all matters related to health and human services.

It is my understanding that more than 800 Treaties, Executive Orders and legal statutes, were declared and negotiated between the United States of America and our native ancestors. These men and women were leaders who shed blood and witnessed the massacre of their people, by the U.S. Army or other Non-Indians who sought to carry out "Manifest Destiny". American Indian and Alaska Native Governments were forced to turn over more than 450 million acres of land with the promise that their sovereign nationhood would be preserved. In exchange for the precious land which sustained a quality lifestyle, our Indian leaders were promised health care, education, housing and other forms of Federal assistance intended to mainstream Indian people into the general society.

Senator Daniel K. Inouye has best captured the historic notion, 'That the first inhabitants of this great land purchased the first pre-paid health care plan in the Country in exchange for their land". And like any negotiated health plan, there are premiums to be paid and minimum benefits to be derived.

Inequity and Injustice

Today, the United States of America is failing to provide 1 00 percent of the health care benefits required in the 'Trust Obligation" provisions of their health care plan. While the Congress and the Administration celebrate their accomplishments in reducing the Federal deficit, nearly half a million Indian patients will go without ambulatory outpatient visitations in the coming year because the basic mandatory costs necessary

to cover inflation and Federal Employee Pay Act increases will have to be absorbed without full increased funding. You might ask how can this happen when the Administration has requested a $170.1 million increase on behalf of the Indian Health Service. The best way that I can demonstrate the injustice affecting Indian health care is to draw you a picture.

IHS Funding Compared with Other Federal Agencies

I present for your review, a comparison or trend analysis of the per capita expenditures available to an Indian health beneficiary versus other Federal Agencies' per capita health expenditures. The agencies represented in this comparison include Medicaid and the Veterans Administration. As you are probably well aware, Medicaid is a health program available to the poor who cannot purchase health care. Medicaid for all its intent and purposes is a welfare program designed to provide a safety net for the Nation's indigent. While the Veterans Administration provides health services to former military personnel.

Unlike Medicaid, the budget of the IHS (which is funded primarily under the authority of the Synder Act) is treated as a discretionary program in the federal budget process. During the past seven years, the enacted appropriations for the IHS grew very slowly with increases between 1 and 3 percent per year. In FY 1999, we were quite pleased to have realized a 5.9 percent increase. Although these increases may have been comparable to or slightly in excess of many federal discretionary programs during this period, they were less than the increases provided to the major federal health care entitlement programs. Medicaid averaged over 10 percent growth per year for the period 1992 to 1996, over 4 times the levels of growth in the IHS budget over the same period.

The trend is not new. The IHS has been struggling to keep pace with the growth in the cost of health care and the rising number of IHS beneficiaries for the past two decades. A report issued by the Department of Health and Human Services in 1986, entitled, *"Bridging the Gap: Report on the Task Force on Parity of Indian Health Services,"* found that expenditures per capita by IHS declined from 75 percent of national expenditure levels in 1975 to less than 69 percent in 1986. In the subsequent decade, this gap widened.

In the FY 2000 President's Budget Request for the IHS, the document indicates that the IHS per capita expenditure is $1,400, compared to the U.S. civilian resident per capita expenditure of $3,200. This would suggest that in FY 2000 the [HS expenditures will provide less than 43 percent of the per capita expenditure for the civilian U.S. population. While this particular comparison looks specifically at the contrast between IHS expenditures and the amount of medical expenditures available to the general population, in today's discussion we look to compare funding for the IHS and other Federal programs comparable to the IHS.

The charts and table attached to my testimony presents the disparity, in actual appropriations and in dollars adjusted for inflation to their spending power in 1993 for the period FY 1993 to FY 1998 for the IHS versus Medicaid and the IHS versus the Veterans Administration. In FY 1993, the actual per capita expenditure for an Indian person in the IHS was $1,442 as compared to $3,042 for a Medicaid beneficiary and $5,249 for a Veterans' Administration beneficiary. Four years later in FY 1997, the per capita expenditure for an Indian person was $1,430 as compared to $3,369 for a Medicaid beneficiary and $5,458 for a Veterans' Administration beneficiary.

The difference between the expenditure for an Indian in an IHS program as compared to a Medicaid beneficiary is $1,939. When adjusted for inflation, the per capita expenditure in FY 1997 for an Indian person in the IHS is $1,217 as compared to $2,600 for a Medicaid beneficiary. (See attached tables).

The difference between the expenditure for an Indian in an IHS program as compared to a Veterans Administration beneficiary is $4,028. When adjusted for inflation, the per capita expenditure in FY 1997 for an Indian person in the IHS is $1,217 as compared to $4,503 for a Veterans Administration beneficiary. (See attached tables).

As you can well observe, Indian people in the Indian Health Service programs are not being served under the Nation's first prepaid health plan at a level which even meets one-third of what is available to a Medicaid and one-fifth of what is available to Veterans' Administration beneficiaries. Even though many Indian people are eligible to participate in Medicaid and Medicare, there are many limitations which confound their participation. Tribal and IHS health programs do not have equal access to these programs due to technical legislative impediments. At the same time, new Medicaid managed care efforts are largely controlled by State governments and managed care providers who will do their best to count Indian patients as a part of their plan, but will not make reasonable reimbursements to Indian health programs. And while improvements have been made to increase reimbursement rates within Indian health programs, the net gains in collections simply do not equal the disparity inherent in the IHS Budget.

The Nation's first pre-paid health plan is failing to meet the Trust obligation, as demonstrated by the FY 1999 IHS Budget. It is quite obvious that American Indians and Alaska Natives in IHS and Tribal programs are treated unequally when compared to Medicaid recipients and Veterans who secure services in other Federal programs.

For purposes of today's hearing, we have looked externally at IHS per capita expenditures as compared to other Federal programs. Internally, there is a growing need for the Congress to provide guidance on behalf of Tribal Governments to ensure that per capita expenditures between IHS and tribal programs are analyzed fully. No one is certain what level of unmet need is valid and true between IHS and tribal facilities. At present there is a systemic, nationwide inconsistency in resource allocation within the IHS, between Areas and between programs.

As the Senate Committee begins to contemplate the reauthorization of the Indian Health Care Improvement Act, we stand ready to assist the Committee in ensuring that facility per capita expenditures are established within the IHS. For how can we expect to clarify the availability of a minimum benefits package for Indian people as part of the nation's first pre-paid health care plan, when facility per capita expenditure information is absent. Without an established baseline in funding and health outcomes, it will be difficult to assess progress in the new century. To this end we have encouraged the establishment of the Level of Need funded workgroup.

Level of Need Funded Workgroup

In the past six months, we have observed the activities of the IHS-chartered workgroup which is undertaking an examination of IHS funding to establish a common estimate of health care funding needs for Indian people. At present, the IHS Resource Requirement Methodology forecasting tools are inadequate for a contemporary nationwide estimate of health needs. To assist the LNF Workgroup, three outside independent contractors have been selected to help the LNF Workgroup identify reasonable approaches for determining health care needs for Indian people.

One of these approaches looks specifically at comparing a comprehensive medical benefits package to the services which should be available under an IHS or tribal health system. It appears that the best means for comparing benefits is derived from the Federal Employee Health Benefits (FEHB) plan which uses a Blue Cross and Blue Shield standard for displaying the variety of FEHB plans that a Federal Employee might consider when selecting a plan. For purposes of establishing comparability, the LNF workgroup has determined which IHS services and programs can be considered as core benefits or as “Wrap Around" public health services. And the LNF Workgroup

has also estimated population variables and current health spending, to ultimately develop a model for comparing funds needed and funds available to determine the level of need within Indian health or tribal health programs.

Early estimates would suggest that $3,391 per person is available for insured persons under a Federal Employee Health Benefits plan, as compared to $1,244 for an Indian person with comparable Blue Cross Blue Shield benefits currently available under an IHS or tribal health program. This is a disparity of $2,147 and is a little over one-third of what a Federal employee secures in their health care. These estimates are not yet final, but confirm the inequity and injustice which Indian people suffer under the present IHS budget. Based on population estimates and current appropriations, including Medicaid and Medicare collections, the total funding needed to bring American Indians and Alaska Natives up to a standard of care available to Federal Employees is $7.78 Billion.

We are well aware that Members of Congress and their staff are also enrolled in the Federal Employee Health Benefits program. In this day and age, when the economy is booming and there are talks about a Budget Surplus, it seems quite reasonable for American Indians and Alaska Natives to ask why they too cannot secure the same care available to the Congress and the Administration. Indian people are not asking for anything more, they merely seek to increase the resources necessary to bring their health status up to a level which is equal to all other citizens. The loss of 450 million acres of land was an extraordinary loss and thus to secure health care under the IHS budget at a level which is one-third of what a Federal Employee or a Medicaid beneficiary presently receives is a true violation of the United States' Trust Responsibility.

Developing a Tribally-driven Budget for the IHS

Nearly three years ago, the National Indian Health Board met with Dr. Michael Trujillo, Director of the Indian Health Service, to propose a new process to develop a tribally-driven Indian Health Service budget. This tribally-driven IHS budget was to be developed with the input of every tribal government in consultation with the IHS. Under the guidance of Dr. Michael Trujillo, every Area of the IHS held two day consultation sessions last spring and Tribal Governmental Officials provided their best recommendations on how IHS funding should be increased and applied to improve health services within the FY 2000 IHS Budget. This same process for the FY 2001 IHS Budget formulation is now underway, where tribal and urban Indian representatives are gathering to meet with I HS representatives on the budget.

The Tribal Needs Based Budget for FY 2000 includes a request of $8,019,281,000, which represents the collective recommendations of each of the twelve Areas of the IHS, their Tribal programs and urban Indian health projects. The budget provides for an additional $2.6 billion for Services and $2.9 billion for Facilities, above the FY 2000 IHS request to provide access to high quality primary and secondary medical services, basic preventive services and the infrastructure for service provision. The current proposed FY 2000 President's Budget request of $2.4 billion represents a growing disparity between Indian and non-Indian citizens. (See attached Table which identifies Tribal Priorities for FY 2000.)

Today, we respect the effort of Dr. Trujillo and his staff for holding these consultation sessions. Yet it is truly disappointing that tribal priorities are overlooked when for the second time in the history of the IHS, Tribal Governments have recommended a practical approach for improving health care in Indian Country. Under Dr. Trujillo's leadership, the National Indian Health Board, the Tribal Self-Governance Advisory Committee and the Urban Indian Health Council have joined forces to advocate for an increase in the FY 2000 Indian Health Service budget.

NIHB Priorities

My colleagues on the National Indian Health Board and other Tribal leaders join me in strongly recommending an increase of $543,881,000 for the Indian Health Service in Fiscal Year 2000 over the enacted FY 1999 appropriation of $2,242,287,000. An increase of $543.8 million would restore major reductions in IHS programs realized over the past seven fiscal years and would amount to a total appropriation of $2,786,168,000 in FY 2000. The amount of funding recommended over and above the President's request of $2,412,387,000 for FY 2000, is $373,781,000.

While we are only requesting less than one-tenth of the comprehensive tribal-based needs budget, we feel these priority areas should be funded in FY 2000. The increase of $543,881,000 includes $126,730,000 for full Contract Support Cost funding, $1 00 million for Contract Health Services, a $1 0 million increase for Community Health Representative programs, $58,151,000 for Pay Act Increases and Inflationary Costs not included in the FY 2000 IHS Request, and $78.9 million for Tribal Health Needs, in addition to the $170.1 million increase provided for in the President's FY 2000 Request.

Full funding for Contract Support Cost and why it is important

Our top priority is to realize a $126.7 million increase in Contract Support Costs in FY 2000. The leadership of the Tribal Self-Governance Advisory Committee also supports this recommendation. While President Clinton and the Congress have strongly encouraged Indian Self-Determination and Self-Governance policy development, the full amount necessary for Contract Support Costs remains absent.. An appropriation of $365,51 1,000 in FY 2000 would provide additional funds for existing contracts and provide the $100 million needed for new and expanding contract support costs. Without the benefit of federal administrative support structures or funding, Tribal Governments cannot be expected to bear the burden of managing programs on behalf of the Federal Government. With the recent publication of final regulations to the 1994 Amendments to the Indian Self-Determination and Education Assistance Act, which was sponsored by Senator McCain and many of the Members of the Senate Committee on Indian Affairs, the need continues to grow.

In 1998, the National Indian Health Board published a year-long study on the policy of Indian Self-Determination and Self-Governance as it affects health care delivery. As you may recall, I and fellow Board Member, Alvin Windy Boy, presented testimony on this study to both the House and the Senate Committee on Indian Affairs during hearings on the Title V Self-Governance legislation.

This descriptive study was national in scope and includes the Tribal perspectives of 210 tribes and tribal organizations, which is representative of 38 percent of the 554 Tribal Governments. Tribal leaders and Tribal health directors were surveyed representing each of the three primary groups of tribes participating in Contracting, Compacting and as IHS direct service tribes. Every IHS administrative Area was represented in the study. According to the health director survey results, the lack of Indian Self-Determination contract support funding was regarded as a barrier to contracting and compacting for 27 percent of the IHS direct service tribes, 28 percent of contracting tribes and 11 percent of compacting tribes.

Despite the limitations of Contract Support Costs funding, on average, every type of tribe - IHS direct service, contracting and compacting - has achieved a higher level of health care since the self-governance demonstration project began. And Tribes more commonly perceive an improvement in the quality of care when they manage their own health care systems. These are only a few of the major conclusions resulting from this study which suggests that if the Federal Government wants to encourage tribal management, full funding for both direct and indirect costs for Tribal management of health services is a key to quality and cost-effective health care.

Full funding for Contract Health Services - Life and Death, Pain and Suffering

There has been no inflationary increase provided for the Contract Health Services program in the past five years. And while the CHS program is the activity most directly affected by Medical Inflation, it has not been recommended for funding increases by the Administration and the Congress. The Contract Health Services program, which helps to purchase hospital-based services, pharmaceuticals and referrals to specialized services such as cancer screening, mammography, gall-bladder surgery, etc., is often the only form of health care available to tribal communities when no other IHS funded source is available. To restore the funding lost and ensure that CHS services are not restricted to only life and limb-saving procedures thru the entire fiscal year, the NIHB recommends a $100 million increase. The NIHB does not agree with the rationing of this program, as new standards of referral force IHS and tribal providers to determine, "Who is in the most pain and who should be referred to alleviate their pain." It is only humane for IHS and Tribal providers to refer everyone who needs a referral to not only sustain life and limbs, but to secure care which is needed to improve their health and well being. And these referrals should be facilitated in every quarter of the fiscal year, not just the first quarter.

Community Health Representatives - First Responders

The NIHB strongly disagrees with the judgement of the Office of Management and Budget related to the Community Health Representative Program which would decrease this program by $5 million to offset an increase in the Public Health Nursing Program. This vital program is nearly 100 percent tribally-run and often serves as the front-line connection and communications link to thousands of Indian people, especially the elderly, disabled or handicapped. We have reviewed the latest data and firmly believe the CHR Program is only funded at 52 percent of need, thereby requiring an increase of $72.7 million more to fully provide the broad array of paraprofessional services needed for successful health promotion and disease prevention initiatives. While we wish to recommend full funding, the NIHB seeks to increase the CHR program by $10 million in FY 2000.

Mandatory Pay Act Increases and Inflationary Costs

The NIHB has reviewed page 13 of the FY 2000 President's Request and is very concerned that Pay Act Increases and Inflationary cost increases which would have sustained current services each year from FY 1993 to FY 1999 has lead to an actual decrease of $359,871,000 in budget authority. More specifically, each year the IHS determines what it will cost to pay all Congressionally mandated Pay Act Increases for it's Federal Employees. And the IHS calculates Medical and Non-Medical inflationary cost increases each year consistent with other Federal programs. (Although the medical deflator is much lower than the inflation factor used in the Consumer Price Index for Medical Services.) Even though these funds are necessary and should be added to the base budget of the IHS each year, they have not been included and are eventually absorbed by the agency in program decreases and staffing reductions.

In Fiscal Year 2000, the entire amount of funding needed to fund Pay Act Increases is estimated to be $40,673,000 (at 4.4 percent) and $52,530,000 is needed for inflation (2.1 percent for non-medical costs and 3.8 percent for medical costs). The total amount which is recommended for funding in FY 2000 by the Administration for Pay Act and Inflation is only $34,752,000 and the amount not recommended for funding is $58,151,000. It is suggested by the Administration that IHS absorb this additional $58.1 million in mandatory fixed costs, thereby leading to a $418,022,000 loss in fixed costs between the period of FY 1993 to FY 2000. While we don't believe the Clinton Administration intends on institutionalizing this type of loss in budget authority, it weighs heavily on the IHS and tribal health programs who have to redirect funds to make up for the mandatory costs which are required under the Pay Act and under inflation. Therefore, we ask the Congress to fully fund Pay Act increases and these modest estimates for inflation at $58,151,000 in FY 2000.

We appeal to the Senate Committee on Indian Affairs to advise the Senate Budget Committee that the Indian Health Service budget has already contributed to the cost savings used to achieve a balanced budget. The loss of $418,022,000 in fixed costs as demonstrated on page 13 of the President's Request is a substantial loss of budget authority. We urge the Indian Affairs Committee to request report language which directs the Department of Health and Human Services and the Office of Management and Budget to ensure that mandatory cost increases due to inflation and Federal Pay Act increases be included in the base budget of the I HS prior to it's earliest deliberations in future budget submissions.

Tribal Health Priorities

We have recommended an additional $78,900,000 to partially fund the tribal health priorities recommended in at least six of the twelve Areas nationwide. This $78.9 million includes a 10 percent increase in the following programs, as identified in the Tribal Needs Based Budget for FY 2000, this includes: $12.1 million increase for Diabetes Programs; $12.1 million increase for Substance Abuse/Alcoholism Programs; $13.1 million increase for Injuries (of which $7.2 million is for Health Promotion/Disease Prevention efforts, $3.6 million is for Emergency Medical Services and $2.3 million for Tribal Environmental Health Programs); $15 million increase for Cancer, principally for Breast and Cervical Cancers; $19.5 million increase for Dental programs; and $7.1 million for Mental Health programs. While the total amount of funding needed to fully fund the top 6 priorities recommended by the budget formulation teams nationwide is ten times greater, we felt it was important to add these increases to those identified by the Indian Health Service within the FY 2000 President's Budget request.

The tragic consequences of the FY 2000 IHS Budget

Tribal leaders and health care providers continue to deal with the impact of the lack of mandatory increases for inflation and Pay Act increases. But what does this mean in terms of health services? Thousands of people will be denied hospital admission, nearly half a million outpatient visits will be reduced, dental services will be cut, mental health and social services will be decreased, public health nursing home visits will not be performed and CHR visits will be severely impacted. The FY 2000 budget does not include sufficient increases for inflation, Contract Support Costs, the phasing in of staffing at new facilities, Pay Act increases, and population growth. And with an unwillingness to fully fund Facilities Construction projects which are ready for funding, program improvements and sanitation needs will go unmet and accreditation of health facilities will be compromised.

Conclusion and Call for Action

Mr. Chairman, in this era of diminishing Federal resources, every health care provider in the Indian Health Service and tribal health programs continues to work day in and day out in an environment where less than 43 percent of the need is being met by the United States Government. All of the health care providers, whether they are denied yearly salary increases or who work in facilities which are at times over 80 years old, are doing their very best to maximize every precious federal dollar appropriated by the U.S. Congress for the benefit of Indian people. And yet they will forced to turn people away or watch Indian people die from lack of appropriate resources. Today, we cannot afford to even ask for more prevention dollars, because the acute care of Indian people is being prioritized in this deficit-reduction mode.

On behalf of the National Indian Health Board, we thank the Indian Affairs Committee for considering our recommendations for improving Indian health programs. I call upon my Indian friends to work together with the distinguished Chairman of the Senate Committee on Indian Affairs to uphold the Treaty commitments our great leaders agreed upon more than a century ago. We seek

to provide the same level of care to our citizens that you would provide to all citizens eligible for Medicaid, the Veterans Administration or the Federal Employee Health Benefits program. It is time to restore the losses realized in the past seven years and support a budget for the IHS in the amount of $2.7 billion in FY 2000. This amount of funding will only meet one fourth of the Tribes declared need, but it is a start and one that is badly needed.

(NOTE: charts in original testimony are unavailable here)